California Newborn Hearing Screening PROGRAM

Hospital Name _____

NEWBORN HEARING SCREENING

Infant Reporting Form

INPATIENT SCREEN COMPLETED

IP Screening	RIGHT EAR		LEFT EAR	
DATE OF SCREENING				
TYPE OF SCREENING *(circle one)*	ABR DPOAE TEOAE	ABR DPOAE TEOAE	ABR DPOAE TEOAE	ABR DPOAE TEOAE
RESULT *(circle one)*	PASS REFER	PASS REFER	PASS REFER	PASS REFER

INPATIENT SCREEN NOT DONE (*fax completed form to HCC*)

☐ Transferred out to: _____ Hospital on (*date*): _____

☐ Missed; discharged without screen ***(complete Follow-Up section below)***

☐ Waived (Face Sheet not required) - ☐ NHSP Brochure given to parent

☐ Expired or physician determined screening not medically indicated (Face Sheet not required)

FOLLOW-UP FOR REFERS/MISSED *(fax completed form to HCC)*

☐ Parent/Legal Guardian information on face sheet verified/updated

Primary Language (Circle One): English Spanish Other:_____

☐ Additional contact information is verified/updated on face sheet or below

Contact Name: _____ Phone: _____

Address: _____

City/Zip: _____

Primary Language (Circle One): English Spanish Other:_____

☐ Print Infant's Full/Legal Name:_____

☐ NHSP Brochure given to parent (Circle One): Pass Refer Refer to DX

☐ Follow-Up Appointment made and written on Parent brochure:

APPOINTMENT: ☐ **OP SCREENING** ☐ **DX EVALUATION FOR NICU PATIENTS**

DATE: _____ **TIME:** _____ ☐ CCS Referral Made

County:_____

PROVIDER: _____ **Phone:** _____

☐ PCP who will see the Infant after discharge – Name: _____

Phone: _____

☐ Completed form faxed ***with hospital face sheet*** to your Hearing Coordination Center at (XXX) XXX-XXXX

PATIENT NAME: _____ ***Addressograph***

Birth Date: _____

☐ **WBN** ☐ **NICU** Name of Birth Hospital if different

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